		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE S COMPLI		
		155689	B. W	ING		09/02/	2015
	ROVIDER OR SUPPLIER		•	2400 C	ADDRESS, CITY, STATE, ZIP CODE OLLEGE AVE EN, IN 46526		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K 0000							
Bldg. 01	State Licensure of the Indiana State accordance with Survey Dates: 0 Facility Number Provider Number AIM Number: 1 At this Life Safe Courtyard Health not in compliance Participation in I CFR Subpart 48. Fire and the 200 Fire Protection A Life Safety Code 16.2. The origin consisting of the wing and the masurveyed with C Health Care Occ This one story fabe of Type V (13 fully sprinklered storage shed on a fire alarm system).	e: 000091 er: 155689 e00290080 ty Code survey, heare Center was found the with Requirements for Medicare/Medicaid, 42 e3.70(a), Life Safety from edition of the National Association (NFPA) 101, the (LSC) and 410 IAC that section of the building a Wing, B Wing, the C in dining room was hapter 19, Existing	K 0	000	Rooo Please accept this Plan of Correction as our facility's Credible Allegation of Complia for our Life Safety Code Recertification and State Licensure Survey conducted of 9/2/15. Submission of this Plan of Correction is not an admission Courtyard Healthcare Center to the deficiencies alleged in the survey are accurate or that the depict the level of safety and security provided to the reside of our facility. This Plan of Correction is being submitted solely because doing so is required by State and Federal law.	n by hat ey nts	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155689		(X2) MULTIPLE A. BUILDING B. WING	O1	(X3) DATE SURVEY COMPLETED 09/02/2015	
	ROVIDER OR SUPPLIER		2400	ET ADDRESS, CITY, STATE, ZIP CODE COLLEGE AVE HEN, IN 46526	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
TAG	corridors. The reprovided with sing smoke detectors, capacity of 186 at the time of this at the time of this access were spring a storage shed or sprinklered and the sized storage shed the facility that were recorded as the sized storage shed or sprinklered and the sized storage shed the facility that were smoken the sized storage shed storage shed the sized storage shed storage	esident rooms are ngle station, hard wired The facility has a and had a census of 173	TAG	DEFICIENCY)	DATE
K 0018 SS=E Bldg. 01	than required enclopenings, exits, or substantial doors, of 1¾ inch solid-be capable of resistin minutes. Doors in only required to resmoke. There is reclosing of the door with a means suitaclosed. Dutch doopermitted. 19.3. Roller latches are regulations in all h 1. Based on obset the facility failed.	orridor openings in other osures of vertical hazardous areas are such as those constructed onded core wood, or g fire for at least 20 sprinklered buildings are sist the passage of to impediment to the st. Doors are provided able for keeping the door ors meeting 19.3.6.3.6 are	K 0018	K018 Facility will equip its corridor doors with latching mechanisms that meet the NI requirements and assure that	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY			JRVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ЛLDING	<u>01</u>	COMPLE	ΓED
		155689	B. W	ING		09/02/2	015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				OLLEGE AVE		
COURTY	ARD HEALTHCAR	E CENTER			EN, IN 46526		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG			DATE
	resident rooms o	n Birch wing were			said doors are smoke resistive).	
	smoke resistive.	This deficient practice			Corrective Actions: The		
	could affect 21 r	esidents on Birch wing.			pencil-sized holes near the do		
		2			knobs of the corridor doors not in the 2567, namely those lead		
	Findings include				to resident room numbers 107	-	
	Tilldings illerade	•			117, 128, and 129 have been	,	
	D 1 1	. 1			repaired. Automatic smoke		
		ation during a tour of the			detector has been installed in	the	
	_	Assistant Maintenance			Staff Lounge. The corridor do		
	Technician and t	he Housekeeping			noted in the 2567, that leads to)	
	Supervisor on 09	0/02/15 at 10:28 a.m.,			room number 218, has been		
	there were penci	l size holes by the door			repaired so it latches	hlo	
	knobs in the cor	ridor doors of rooms,			appropriately. The set of doul corridor doors noted in the 256		
		nd 129. Based on			those leading from the	,,,	
		time of observation, the			Candlelight Dining Room to the	e l	
					Staff Lounge, has been		
	holes were acknowledge				reconfigured to include positive	e	
		nance Technician and			latching as per NFPA.		
	the Housekeepin	g Supervisor.			A smoke detector has been		
					installed in the Staff Lounge.		
					How Others Identified: Hazard Rounds of the building		
	3.1-19(b)				were conducted to determine		
	` '				what other doors may be similar	arlv	
	2 Based on obse	ervation and interview,			deficient. Preventative	, I	
		I to ensure 1 of 33			Measures: These three doors	will	
	_	rridor doors on Cedar			be placed on a Preventive		
					Maintenance Schedule, where		
		latched into the door			they will be checked to assure		
		cient practice could			that they latch appropriately. These checks will occur weekl	,	
	affect 26 residen	ts on Cedar wing.			for the next six months, at which	•	
					time their frequency may be		
	Findings include	:			reduced at the direction of the		
					facility's QAPI Committee.		
	Based on observ	ation during a tour of the			Monitoring: The results of th	е	
		Assistant Maintenance			PM checks notedunder		
	_				"Preventative Measures" (abov	· .	
		he Housekeeping			will be submitted to the facility'		
	Supervisor on 09	0/02/15 at 12:00 p.m., the			QAPI Committee for review on	ı a	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155689	ľ	VILDING NG	nstruction 01	(X3) DATE : COMPL 09/02/	ETED
	PROVIDER OR SUPPLIER			2400 C	ADDRESS, CITY, STATE, ZIP CODE OLLEGE AVE EN, IN 46526		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	corridor door to to latch into the dinterview at the twas acknowledg Maintenance Tea Housekeeping St. 3.1-19(b) 3. Based on obsetthe facility failed double corridor from closed and into the door fran practice was not but could affect stroom. Findings include Based on observe facility with the Technician and the Supervisor on Ostaff dining room of double corridor double corridor double doors was acknowledged.	resident room 218 failed door frame. Based on time of observation, this ed by the Assistant chnician and the appervisor. ervation and interview, I to ensure 1 of 1 sets of doors to the staff dining latched automatically me. This deficient in a resident care area staff using the dining			CROSS-REFERENCED TO THE APPROPRIA		
	Additionally, the	the second door d into the first door. ere was a manual exterior tionally, the staff dining					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED
		155689	B. WING		09/02/2015
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
COURTY	ARD HEALTHCAR	F CENTER		OLLEGE AVE EN, IN 46526	
				I	(7/5)
(X4) ID PREFIX		FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE
	room was not pro	otected by an automatic			
	smoke detector.	Based on interview at			
	the time of obser	vation, this was			
	acknowledged by	y the Assistant			
	Maintenance Tec	chnician and the			
	Housekeeping Su	upervisor.			
	3.1-19(b)				
K 0025	NFPA 101	DE CTANDADD			
SS=F Bldg. 01	LIFE SAFETY CO Smoke barriers are	e constructed to provide at			
Diag. 01		our fire resistance rating in			
		.3. Smoke barriers may			
		ium wall. Windows are			
		ated glazing or by wired steel frames. A minimum			
		empartments are provided			
		npers are not required in			
	•	of smoke barriers in fully			
	ducted heating, ve conditioning system				
	19.1.6.3, 19.1.6.4	, 10.0.1.0,			
	Based on observa	ation and interview, the	K 0025	K025 NFPA LIFE SAFETY	10/02/2015
	facility failed to	ensure 1 of 1 ceiling		CODE STANDARD Facility wi	
	smoke barriers w	as maintained to provide		continue to ensure that smoke barriers are constructed to	
	a one half hour f	ire resistance rating.		provide at least a one half hou	r
	LSC 8.3.2 requir	es smoke barriers shall		fire resistance rating in	
	be continuous fro	om an outside wall to an		accordance with 8.3. Correct	iive
	outside wall. Th	is deficient practice		Actions: The smoke barrier penetrations noted during the	
	could affect all re	esidents in all smoke		survey have been repaired.	low
	compartments.			Others Identified: As noted i	n
	T. 1			the 2567, this alleged deficient practice could affect all of the	;
	Findings include	:		facility's residents. Preventat	ive
				Measures: Smoke barriers	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155689		A. BUILDING B. WING	<u>01</u>	COMPLETED 09/02/2015	
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE OLLEGE AVE	
COURTY	'ARD HEALTHCAR	E CENTER		EN, IN 46526	
(X4) ID PREFIX TAG	(EACH DEFICIEN	CATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	5.112
	facility with the lassistant Mainte the Housekeepin 09/02/15 between p.m., the following were noted: a.) in the ceiling the maintenance unsealed penetration around the ceiling server closet their penetration around measuring two in c.) in the ceiling storage room the penetration around measuring one and d.) in the ceiling adjacent to the modern were 7 unsealed electrical conduits size. e.) in the ceiling room by the maind 2 unsealed penetration in size. f.) in the ceiling storage room the ceiling room by the maind 2 unsealed penetration in size. f.) in the ceiling storage room the storage r	in 10:00 a.m. and 1:00 ing unsealed penetrations of the electrical room in shop there were 17 tions around electrical ing a quarter inch to a shop the of the Birch wing in the was an unsealed individual individual individual individual inch in size. The speaker room in the computer server in dining room there in the computer server in dining room there were rations around electrical ing a quarter inch to a half inch in the computer server in the computer inch to a half inch in the computer server in the compute		have been placed on a schedul whereby they will be visually checked for compliance with K025 monthly for the next six months. Documentation of the observations will be forwarded the facility's QAPI Committee for review. Monitoring: The results of the visual checks completed under "Preventive Measures" (above) will be reviewed by the facility's QAPI Committee at each meeting it holds in the next six months. Date of Completion: October 2015	ese to for

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>01</u> COMPLETED B. WING 09/02/2015				
		155689	B. WI			09/02/	2015
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2400 COLLEGE AVE GOSHEN, IN 46526				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
K 0038 SS=E Bldg. 01	Assistant Mainte the Housekeepin acknowledged ar measurements of 3.1-19(b) NFPA 101 LIFE SAFETY CO Exit access is arrareadily accessible with section 7.1. 1. Based on obsethe facility failed egress through 1 locks in the Birch accessible for resvisitors. LSC 7.2 Locks, says appregress locks shall installed on door ordinary hazard oprotected through supervised auton system installed Section 9.6, or an automatic sprink accordance with permitted in Chaprovided: (c) An shall release the upon application	Director of Maintenance, mance Technician, and g Supervisor and provided the Sthe penetrations. DE STANDARD nged so that exits are at all times in accordance	K 00	038	K038 NFPA 101 LIFE SAFETY CODE STANDARD Facility we continue to have its exits arranged so as to be readily accessible at all times. Corrective Actions: The Bird Wing multi-purpose room door noted in the 2567, has been repaired so as to provide for the 15/3 second requirements noted on page 6 of the 2567. The Dining Room exit has been equipped with signage indicating "PUSH UNTIL ALARM SOUND DOOR CAN BE OPENED IN 1 SECONDS". The activity room doors, noted in the 2567, have been equipped with appropriate signage. How Others Identified: This alleged deficiency has the potential to affect all of the facility's resider Preventative Measures: Maintenance Supervisor has been trained on the delayed egress requirements noted in	ill th	10/02/2015

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155689		l í	ILDING	nstruction 01	(X3) DATE : COMPL 09/02/	ETED	
	PROVIDER OR SUPPLIER			2400 C0	ADDRESS, CITY, STATE, ZIP CODE OLLEGE AVE EN, IN 46526		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	be required to extrequired to be comore than 3 second the release process audible signal in Once the door look the application of device, relocking means only. This affect 33 resident the Birch hall. Findings included Based on observing facility with the Technician and the Supervisor on Observing the building is exit, is equipped lock, and is proving signage stating the failed to open with the door was pussed force five septimetries at the the Assistant Mainter the Housekeeping aforementioned and the second	acceed 15 seconds nor continuously applied for conds. The initiation of conds. The initiation of conds shall activate an the vicinity of the door. The condition of the door condition of the released by the force to the releasing condition of the condition of th			"K038". Monitoring: All of the facility' exit and fire doors have been placed on a Preventative Maintenance schedule and wil checked for: (a) signage—if appropriate; (b)15/3 second requirements—if locked; and (latching—if fire doors. Said Pl checks will occur weekly for th next six months, with the resul forwarded to the facility's QAP committee for review and follow-up. Date of Completic October 2, 2015	l be c) M e ts	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155689		` ′	ILDING	nstruction 01	(X3) DATE COMPL 09/02 /	ETED	
	PROVIDER OR SUPPLIER			2400 C	DDRESS, CITY, STATE, ZIP CODE DLLEGE AVE N, IN 46526		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	the necessary sig the exit door fail seconds when the application of times. 3.1-15(b) 2. Based on obset the facility failed doors in the main accessible. Health permit delayed-econditions of LS met. LSC 7.2.1.6 adjacent to the rebe a readily visit not less than 1 in 1/8 inch in width background that "PUSH UNTIL".				CROSS-REFERENCED TO THE APPROPRIA	TE	
	SECONDS " Th	nis deficient practice residents in the main					
	Findings include	:					
	the facility with Maintenance Te Housekeeping S	chnician and the upervisor on 09/02/15 at xit door in the main					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155689	l í	JILDING	nstruction 01	(X3) DATE COMPL 09/02/	ETED
	PROVIDER OR SUPPLIER			2400 CC	DLLEGE AVE N, IN 46526		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	pushing the door lacked proper sig the door to open the time of obser Maintenance Ted Housekeeping State door was equivered delay and there were garding pushing 3.1-15(b) 3. Based on obset the facility failed egress through 2 egress from the areadily accessible clinical diagnosis security measure requires doors we egress shall not be or lock that requires doors we egress shall not be or lock that requires doors we egress shall not be or lock that requires doors we egress shall not be or lock that requires doors we egress shall not be or lock that requires doors we egress shall not be or lock that requires doors we egress shall not be or lock that requires doors without delayed in health care occupational needs of specialized security provided unlock such doors.	appervisor acknowledged apped with a 15 second was not proper signage ag the door to open. Arvation and interview, a to ensure the means of of 2 exits in the path of activity room were as requiring specialized as LSC 19.2.2.2.4 athin a required means of the equipped with a latch are the use of a tool or ess side. Exception No. ocking arrangements arrangements arrangements are gress shall be permitted cupancies, or portions of pancies, where the the residents require rity measures for their that staff can readily at all times. This are affects at least 10					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155689		A. BUILDING B. WING	<u>01</u>	COMPLETED 09/02/2015
	PROVIDER OR SUPPLIER ARD HEALTHCARE CENTER	2400 C	ADDRESS, CITY, STATE, ZIP CODE OLLEGE AVE EN, IN 46526	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Findings include:			
	Based on observations during a tour of the facility with the Assistant Maintenance Technician and the Housekeeping Supervisor on 09/02/15 at 10:18 a.m., the exit doors in the activity room and in the sun room were magnetically locked and could be opened by entering a four digit code, but no code was posted to ensure the doors are capable of being readily unlock. The doors did not require locking because residents that had access to the doors do not have a clinical diagnosis to be in a secure building or wing. Based on interview at the time of observation, the Assistant Maintenance Technician and the Housekeeping Supervisor acknowledged there was no code posted at the two magnetically locked exits. 3.1-19(b)			
K 0044 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5			
	Based on observation and interview, the facility failed to ensure 1 of 3 fire door sets was arranged to automatically close and latch. LSC 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to	K 0044	K044 NFPA 101 LIFE SAFET CODE STANDARD Facility we continue to ensure that its horizontal exists are in accordance with 7.2.4. Corrective Actions: The first door noted in the 2567, leading	vill

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ЛLDING	01	COMPLETED	
		155689	B. W	ING		09/02/	2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	8			OLLEGE AVE		
COURTY	ARD HEALTHCAR	RE CENTER			EN, IN 46526		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		r automatic closing in			Birch Wing, has been adjusted it latches into the door frame.	l so	
	accordance with	7.2.1.8. In addition			How Others Identified: All fir	· P	
	NFPA 80, Standard for Fire Doors and				doors have been checked for	C	
	Windows at 2-1.	4.1 requires all closing			proper latching. Preventative	•	
	mechanisms sha	ll be adjusted to			Measures: Maintenance sta	ff	
	overcome fire re	esistance of the latch			have been trained on the spec		
	mechanism so th	nat positive latching is			requirements of fire doors and		
		h door operation. This			their proper functioning. Monitoring: All of the facility'	e l	
		e could affect 20			exit and fire doors have been	3	
	residents in the I				placed on a Preventative		
		znen wing.			Maintenance schedule and wil	l be	
	Findings include				checked for: (a) signage—if appropriate; (b) 15/3 second		
	Tilldings illerade						
	D 1 1	-4: 1 -: 4 C41			requirements—if locked; and (latching—if fire doors. Said Pl		
		ration during a tour of the			checks will occur weekly for th		
	1	Assistant Maintenance			next six months, with the resul		
		the Housekeeping			forwarded to the facility's QAP		
	•	9/02/15 at 10:20 a.m., the			committee for review and		
	fire door set ente	ering the Birch wing			follow-up. Date of Completion	n:	
	failed to latch in	to the frame. Based on			October 2, 2015		
	interview at the	time of observation, this					
	was acknowledg	ged by the Assistant					
	Maintenance Te	chnician and the					
	Housekeeping S	upervisor and confirmed					
	these were fire d	-					
	3.1-19(b)						
	0.1 17(0)						
K 0046	NFPA 101						
SS=C	LIFE SAFETY CC	_					
Bldg. 01		ig of at least 1½ hour					
	19.2.9.1.	ed in accordance with 7.9.					
		ration, and interview; the	K 0	046	 K046 NFPA 101 LIFE SAFET	Y	10/02/2015
		ensure emergency light		0.10	CODE STANDARD Facility wil		10,02,2013
	facility failed to	chance chiefgency light			continue to supply emergency		

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	OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155689	(X2) MULTIPLE CO A. BUILDING B. WING	O1	(X3) DATE SURVEY COMPLETED 09/02/2015
	NAME OF PROVIDER OR SUPPLIER COURTYARD HEALTHCARE CENTER		ADDRESS, CITY, STATE, ZIP CODE OLLEGE AVE EN, IN 46526	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	fixtures for 2 of 2 generators were tested annually for 1½ hour duration and monthly for 30 second duration in accordance with LSC 7.9. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires an annual test shall be conducted on every required battery powered emergency lighting system for a minimum of 1½ hour duration and every required battery powered emergency lighting system at 30 day intervals for a minimum of 30 seconds. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all occupants. Findings include:		lighting in accordance with 7.9. Corrective Actions: Emergency lighting, already i place at the time of the survey was put on a Preventative Maintenance/testing schedule. How Others Identified: This alleged deficiency has the potential to affect all of the facility's residents. Preventative Measures: Maintenance Supervisor has been trained of the need to test emergency lighting for the generators. Monitoring: Testing of the emergency lighting of the generators has been added to facility's Preventive Maintenar Program and records indicating that the lighting have been checked monthly will be review by the Executive Director (and facility's QAPI Committee) monthly. Date of Completions October 2, 2015	on the nce 199 wed I the
	Based on record review with the Director of Maintenance on 09/02/15 at 10:00 a.m., no documentation was available for		October 2, 2015	
	review to show the testing of the emergency battery powered lights at the facility's two generators. Based on interview at the time of record review, when ask if the emergency battery powered lights are tested 30 seconds monthly, 90 minutes annually, and if the tests are documented the Director of Maintenance stated the emergency battery powered lights are not tested for			

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l f		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING <u>01</u> COMPLETED			
		155689	B. WING 09/02/2015		
NAME OF I	DOWNER OF CURRINE		STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	ROVIDER OR SUPPLIER		2400 C	OLLEGE AVE	
COURTYARD HEALTHCARE CENTER			GOSHE	EN, IN 46526	
(X4) ID	SUMMARY S	SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	*		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	30 seconds mont				
	annually, or doc	umented.			
	3.1-19(b)				
K 0051 SS=B Bldg. 01	NFPA 101 LIFE SAFETY CO A fire alarm syster components, devicinstalled according Fire Alarm Code, warning of fire in a Activation of the cis by manual fire a detection or exting Pull stations in parbe omitted provide stations are within stations. Pull station egress. Electrotests are available of power is provide are maintained in and records of ma available. There is the fire alarm syst station. 19.3.4, Based on observing facility failed to detectors in the Cowas installed who adversely affect 9.6.1.4 requires a single components.	m with approved ces or equipment is g to NFPA 72, National to provide effective any part of the building. complete fire alarm system alarm initiation, automatic guishing system operation. tient sleeping areas may ed that manual pull 200 feet of nurse's ions are located in the path onic or written records of e. A reliable second source ed. Fire alarm systems accordance with NFPA 72 iintenance are kept readily s remote annunciation of em to an approved central	K 0051	K051 NFPA 101 LIFE SAFET CODESTANDARD Facility wood continue to maintain its fire ala system in compliance with K08 Corrective Actions: The smooth of the Cedar Wing multi-purpose room was move so as to be located more than	ill arm 51. ooke
	Alarm Code. NI in spaces served detectors shall no	FPA 72, 2-3.5.1 requires by air handling systems, ot be located where air peration of the detectors.		three feet from theair supply d How Others Identified: This alleged deficiency has the potential to affect all of the facility's residents. Preventat Measures: Maintenance	S

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		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 01 COMPLETED			
		155689	B. WING		09/02/2015
	PROVIDER OR SUPPLIER		2400	ET ADDRESS, CITY, STATE, ZIP CODE O COLLEGE AVE SHEN, IN 46526	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	residents in the Croom. Findings included Based on observe facility with the Technician and a Supervisor on 00 smoke detector is room was located air supply duct, the time of observe acknowledged by the company of	ration during a tour of the Assistant Maintenance the Housekeeping 9/02/15 at 12:10 p.m., the in the Cedar multipurpose d within three feet of an Based on interview at rvation, this was y the Assistant chnician and the		Supervisor has been trained of the requirements noted in K08 Monitoring: Smoke detector have been added to the facilit Hazards Rounds audit that wa instituted as a part of the facilit Health Survey earlier this month. Hazard Rounds are be conducted weekly, and will be the next six months. Results Hazards Rounds are being submitted to the Executive Director (and the facility's QAI Committee) for review and corrective action, if necessary Date of Completion: Octobe 2015	51. rs y's as as ity's eing of
K 0062 SS=B Bldg. 01	continuously mair condition and are periodically. 19 NFPA 25, 9.7.5 Based on observ facility failed to heads in the Cede continuously main operating conditional all automatic sprinspected, tested	DDE STANDARD tic sprinkler systems are ntained in reliable operating inspected and tested 1.7.6, 4.6.12, NFPA 13, ration and interview, the ensure 1 of 1 sprinkler lar store room was intained in reliable ion. LSC 9.7.5 requires rinkler systems shall be I and maintained in NFPA 25, Standard for	K 0062	K062 NFPA LIFE SAFETY CODE STANDARD Facility v continue to ensure that require automatic sprinkler systems a continuously maintained in reliable operating condition ar are inspected and tested periodically. Corrective Actions: The paint noted in the	ed re nd

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		X1) PROVIDER/SUPPLIER/CLIA				X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>01</u>		COMPLETED		
		155689	B. WIN	IG		09/02/	2015
COURTY	ROVIDER OR SUPPLIER	E CENTER		2400 CO GOSHE	DDRESS, CITY, STATE, ZIP CODE DLLEGE AVE IN, IN 46526		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	of Water-Based NFPA 25, 1998 any sprinkler shapainted, corroder the improper orion practice could affect Cedar wing. Findings include Based on observe facility with the Technician and the Supervisor on 9/ paint was noted the Cedar storage interview at the the Assistant Mainter the Housekeeping	ation during a tour of the Assistant Maintenance he Housekeeping 02/15 at 12:05 p.m., on the sprinkler head in e room. Based on time of observation, the mance Technician and			2567, on the sprinkler head in Cedar Wing storage room, has been removed. How Others Identified: All sprinkler heads in the building have been assessed head-by-head and each that w found to have paint on them had either had the paint removed of have been replaced. Preventative Measures: Sprinkler heads are on a Preventive Maintenance schedule whereby they will be checked for paint and corrosion every three months for the next year, with the results of this PN check being forwarded to the facility's QAPI Committee for follow-up and review. Monitoring: QAPI Committee will review the sprinkler head audits for the next year. Date Completion: October 2, 2015	as ave or n tt //	
K 0073 SS=B Bldg. 01	flammable character 19.7.5.3, 19.7.5.4 Based on observe to ensure 1 of 13	decorations of highly	K 00	73	K073 NFPA LIFE SAFETY CODE STANDARD Facility w continue to ensure that its furnishings and decorations ar		10/02/2015

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155689	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 09/02/2015
	PROVIDER OR SUPPLIER		2400 C	ADDRESS, CITY, STATE, ZIP CODE OLLEGE AVE EN, IN 46526	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE
	in room 135. Findings include Based on observe Maintenance Tec Housekeeping Sc 10:45 a.m., there a wick in room 1 at the time of observe Maintenance Tec Housekeeping Sc there was a cand they could not re time because the	ations with the Assistant chnician and the appervisor on 09/02/15 at was an unlit candle with 35. Based on interview servation, the Assistant		not highly flammable. Corrective Actions: The win the candle in room #135 has been removed. How Others Identified: Facility has instit Hazards Rounds whereby furnishings and decorations a being assessed for violations K073. Preventative Measur Hazards Rounds will be completed weekly for the nex weeks and monthly for the formonths following those 8 weel Items found in violation of K0 will be removed when found during Rounds. Social Services, Admissions, and Maintenance staff will be in-serviced on what items are considered hazardous and th facility's protocol for handling items. Monitoring: Hazard Rounds finding are being submitted to the Executive Director, who will summarize finds and present them to the facility's QAPI Committee for review monthly for the next si months. Date of Completion October 2, 2015	e said s
K 0147 SS=E Bldg. 01	facility failed to cords such as an used as a substitu	nd equipment is in IFPA 70, National	K 0147	K147 NFPA LIFE SAFETY CODE STANDARD Facility of continue to ensure that its electrical wiring and equipme are in accordance with NFPA National Electric Code.	nt

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155689	î ´	JILDING	ONSTRUCTION 01	(X3) DATE COMPL 09/02	ETED
NAME OF PROVIDER OR SUPPLIER COURTYARD HEALTHCARE CENTER			2400 C	ADDRESS, CITY, STATE, ZIP CODE OLLEGE AVE EN, IN 46526			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE
	not used as a subto provide power current draw. Note that the permitted is permitted, flexible not be used as a wiring of a structure practice could after in rooms 118, 20 storage on Cedar findings included. Based on observing facility with the Technician and the Supervisor on 09 a.m. and 12:35 proted: a.) a refrigerator an extension cordinate the structure and extension cordinate the structure of the structu	ostitute for fixed wiring requipment with a high FPA 70, National 1999 Edition, Article nat, unless specifically ble cords and cables shall substitute for fixed ture. This deficient fect 4 residents and staff 06 and housekeeping r wing.			Corrective Actions: The p strips and extension cords not in the 2567 have been remove How Others Identified: Fact has instituted Hazards Round which includes the identificat and assessment of the use of extension cords and power is Preventative Measures: Hazards Rounds will be completed weekly for the new weeks and monthly for the formonths following those 8 well tems found in violation of K1 will be removed when found during Rounds. Social Service Admissions, and Maintenancy staff will be in-serviced on K1 and hazards and the facility's protocol for handling said iter Monitoring: Hazards Round findings are being submitted the Executive Director, who is summarize the finds and presented the the facility's QAPI Committee for review monthal the next six months. Date of Completion: October 2, 201	oted ved. sility ds, sion f trips. tt 8 ur eks. 47 ces, e 47 ships. ds tto vill seent	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	A. BUILDING <u>01</u> COMP		
		155689	B. WING		09/02/2015
		<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER	₹		COLLEGE AVE	
	ARD HEALTHCAR	RE CENTER	GOSH	IEN, IN 46526	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCT)	DATE
	and the Houseke	eeping Supervisor.			
	2.1.10(1)				
	3.1-19(b)				
K 0000					
Bldg. 02					
	1	ode Recertification and	K 0000	K000	
	State Licensure	Survey was conducted by		Please accept this Plan of Correction as our facility's	
	the Indiana State	e Department of Health in		Credible Allegation of Complia	ance
	accordance with	42 CFR 483.70(a).		for our Life Safety Code	
				Recertification and State	
	Survey Dates: 0	09/02/15		Licensure Survey conducted of	on
	,			9/2/15.	
	Facility Number	000091		Submission of this Plan of Correction is not an admission	n hy
	Provider Number			Courtyard Healthcare Center to	-
	AIM Number:			the deficiencies alleged in the	l l
	7 HIVI I VAINOCI.	100230000		survey are accurate or that the	э у
	Surveyor: Denn	is Austill, Life Safety		depict the level of safety and	ta
	Code Specialist	iis rustiii, Dire Sulety		security provided to the reside of our facility. This Plan of	ents
	Code Specialist			Correction is being submitted	
	At this I if Sef	aty Codo guryoy		solely because doing so is	
	At this Life Safe	•		required by State and Federal	
		heare Center was found		law.	
	_	ce with Requirements for			
		Medicare/Medicaid, 42			
	_	3.70(a), Life Safety from			
		0 edition of the National			
		Association (NFPA) 101,			
	Life Safety Code	e (LSC) and 410 IAC			
	16.2. The new 2	2011 addition of the			
	building consists	ing of the D Wing was			
	_	hapter 18, New Health			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155689		A. BUILDING B. WING	02	COMPLETED 09/02/2015
NAME OF PROVIDER OR SUPPLIER COURTYARD HEALTHCARE CENTER		2400 CC	DDRESS, CITY, STATE, ZIP CODE DLLEGE AVE N, IN 46526	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	Care Occupancies. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in areas open to the corridors. The resident rooms are provided with single station, hard wired smoke detectors. The facility has a capacity of 186 and had a census of 173 at the time of this survey. All areas where residents have customary access were sprinklered. The facility had a storage shed on the roof that was not sprinklered and two detached, garage sized storage sheds used for storage by the facility that were not sprinklered. Quality Review completed 09/10/15 - DA			
K 0025 SS=F Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one-hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels in approved frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 18.3.7.3,			

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	<u> </u>			COMPLETED	
155689		B. W	ING		09/02/2015		
NAME OF F	PROVIDER OR SUPPLIEI	}	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					OLLEGE AVE		
COURTY	ARD HEALTHCAR	RE CENTER		GOSHE	EN, IN 46526		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	· ·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		
TAG	18.3.7.5, 18.1.6.3	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
		vation and interview, the	K 0	025	K025 NFPA LIFE SAFETY	10/02/2015	
		ensure 1 of 1 ceiling	KU	023	CODE STANDARD Facility w		
	_				continue to ensure that smoke		
		was maintained to provide			barriers are constructed to		
		fire resistance rating.			provide at least a one half hou	r	
	_	res smoke barriers shall			fire resistance rating in accordance with 8.3. Correc :	tivo	
		om an outside wall to an			Actions: The smoke barrier		
		nis deficient practice			penetrations noted during the		
	could affect all 1	residents in all smoke			survey have been repaired.	How	
	compartments.				Others Identified: As noted i		
					the 2567, this alleged deficien	t	
	Findings include:				practice could affect all of the		
					facility's residents. Preventat Measures: Smoke barriers	ive	
	Based on observ	vation during a tour of the			have been placed on a schedu	ıle	
		Director of Maintenance,			whereby they will be visually		
	1	ween 10:00 a.m. and			checked for compliance with		
		llowing unsealed			K025 monthly for the next six		
	penetrations wer				months. Documentation of the		
		of the Dogwood janitor'			observations will be forwarded the facility's QAPI Committee		
		as an unsealed penetration			review. Monitoring: The		
		_			results of the visual checks		
		ight wires measuring one			completed under "Preventive		
	inch in size.	afda Dama a			Measures" (above) will be		
	'	g of the Dogwood			reviewed by the facility's QAP	İ	
		there was an unsealed			Committee at each meeting it holds in the next six months.		
	_	nd the call light wires			Date of Completion: October	r 2,	
	measuring one is				2015	·	
	'	of the Dogwood storage					
	*	rsing station there was an					
	unsealed penetra	ation around the call light					
	wires measuring	one inch in size.					
	Based on intervi	ew at the time of					
	observation, the	Director of Maintenance,					
	· ·	enance Technician, and					
	the Housekeepir						
		<i>C</i> F					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155689		A. BUILDING 02 COMPLETED 09/02/2015					
NAME OF PROVIDER OR SUPPLIER COURTYARD HEALTHCARE CENTER				2400 CC	DDRESS, CITY, STATE, ZIP CODE DLLEGE AVE N, IN 46526		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	(X5) COMPLETION DATE
K 0046 SS=C Bldg. 02	acknowledged at measurements of 3.1-19(b) NFPA 101 LIFE SAFETY CO Emergency lighting duration is provided 18.2.9.1 Based on observe facility failed to fixtures for 2 of 2 annually for 1½ monthly for 30 seaccordance with Periodic Testing Equipment required be conducted on powered emerge minimum of 1½ required battery lighting system at minimum of 30 seaccordance with powered emerge minimum of 30 se	DE STANDARD g of at least 1½ hour d in accordance with 7.9. ation, and interview; the ensure emergency light 2 generators were tested hour duration and econd duration in LSC 7.9. LSC 7.9.3 of Emergency Lighting res an annual test shall every required battery ncy lighting system for a hour duration and every powered emergency at 30 day intervals for a seconds. Equipment shall nal for the duration of	K 004		K046 NFPA 101 LIFE SAFET CODE STANDARD Facility wil continue to supply emergency lighting in accordance with 7.9. Corrective Actions: Emergency lighting, already ir place at the time of the survey was put on a Preventative Maintenance/testing schedule. How Others Identified: This alleged deficiency has the potential to affect all of the facility's residents. Preventative Measures: Maintenance Supervisor has been trained o the need to test emergency lighting for the generators.	Y	10/02/2015
	inspections and to owner for inspection having jurisdiction	records of visual ests shall be kept by the tion by the authority on. This deficient fect all occupants.			Monitoring: Testing of the emergency lighting of the generators has been added to facility's Preventive Maintenan Program and records indicatin that the lighting have been checked monthly will be review by the Executive Director (and	ice g ved	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155689	ì í	JILDING	ONSTRUCTION 02	(X3) DATE : COMPL 09/02/	ETED
NAME OF PROVIDER OR SUPPLIER COURTYARD HEALTHCARE CENTER			<u> </u>	2400 C	ADDRESS, CITY, STATE, ZIP CODE OLLEGE AVE EN, IN 46526	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Based on record Maintenance on no documentation review to show the emergency batter facility's two geninterview at the when ask if the elights are tested minutes annually documented the stated the emerging lights are not tested.	review with the Director 09/02/15 at 10:00 a.m., on was available for			facility's QAPI Committee) monthly. Date of Completion: October 2, 2015		

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